

The Impact of Staffing Moratoria on the Delivery of Quality Health Care Services in the Department of Health

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Abstract

South Africa by international standards has a poor public healthcare system. There has been a substantial increase in the literature on reforms such as austerity measures to improve healthcare service delivery in government health institutions. The global crisis of 2008/2009 forced the government to implement cost-cutting measures to reduce public expenditure and resolve budgetary pressures, including in the health sector. This paper adopted a mixed method to investigate the impact of staffing moratoria in the delivery of healthcare services in the Department of Health. 177 survey questionnaires were distributed to healthcare workers and 9 key informants were interviewed regarding staffing moratoria. Quantitative data was analysed using descriptive statistics, Chi-square tests of association and the Cramer's V test whilst qualitative data was analysed thematically. The results showed that staffing moratoria resulted in severe staff shortages and the deterioration of working conditions as a result of excessive working hours, job enlargement, and limited personal development opportunities. Staffing moratoria also promoted distrust between employees and management that furthered job dissatisfaction at the workplace. The paper concludes that staffing moratoria should be supported by a decentralised multi-dimensional approach in planning and implementation to ensure a collective consultative process involving all relevant stakeholders.

Keywords: Healthcare; Service delivery; Staffing moratoria; Budgetary pressures; Job enlargement

Introduction

In September 2015, the provincial Department of Health implemented a moratorium restricting the filling of vacant posts within public medical facilities as part of its cost-cutting measures (Circular No. PT (12) of 2015/2016 of 15 September, 2015). This was followed by another circular, this time from the national Department of Public Service and Administration (DPSA) also announcing the freezing of posts in the public services sector including health services (Public Service Vacancy Circular No 08 of 2016). The Department of Health followed up on the latter with another circular (KZN DoH HRM Circular No. 18/2016) all restricting the free recruitment of public healthcare workers.

As stated by the Provincial Treasury, the aim behind the implementation of such cost-cutting measures was to ensure efficiency savings, prioritising spending on service delivery, and cutting down on wasteful expenditure (Magagula, 2016). Thus, moratoria that affected the hiring of staff at public health facilities were put in place and have been regulating the employment of healthcare workers in public health institutions to date. Tempo Hospital (pseudonym) is one such facility that operates under these moratoria and this study uses a case study of this hospital to investigate staff and organizational performance at this facility. In addition, the study examines the effectiveness of task-shifting which has been informally adopted by Tempo Hospital as an attempt to optimise operational efficiency through the redistribution of duties and responsibilities across available human resources to cope with the staffing moratoria. Thus, the capacity of TH staff to provide service excellence in healthcare to the public as mandated by the Constitution of South Africa of 1996 will be examined as a function of cost-cutting measures, particularly staffing moratoria, and of task-shifting strategies from the perspective of the healthcare workers.

Literature Review

Theoretical Framework: The Manpower Planning Theory (MPT)

In this paper, the MPT is associated with the works of Makridakis and Hidon (1979). The MPT is one of the major models applied by the World Health Organisation in the forecasting of healthcare labour demand and supply (Smits et al. 2010). The theory is based on the premise that health management systems, which might be as small as a single medical facility to the national health system at large, have a set of predetermined objectives (WHO, 2010). These objectives require the formulation and implementation of strategies that ensure that there is an equilibrium between the demand and supply of healthcare labour. This equilibrium can be current, as when health authorities plan to meet occurring health needs and objectives. The equilibrium can also be planned and in this case forecasting the supply and demand needs of health care workers, based on foreseen future dynamics becomes necessary (Smits et al.2010). Parma et al. (2013) further expand on this to add that manpower planning, in theory, focuses on three aspects: providing the right



number of employees with the right skills, and expertise at the right time and place. Such a provision is what enhances an organisation's ability to meet its objectives.

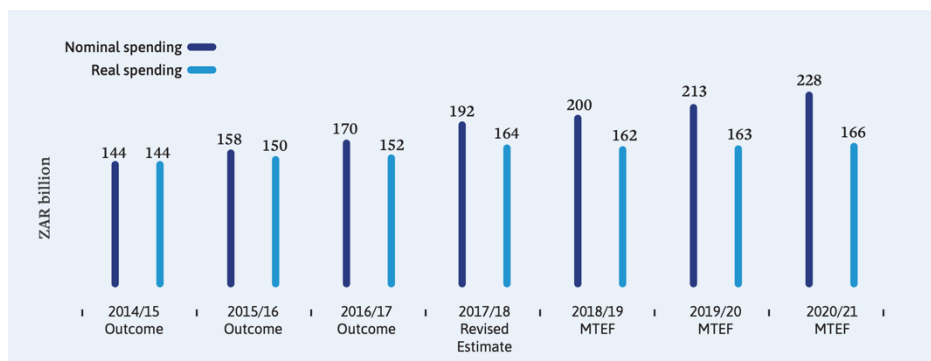
In the theory, if the supply of labour is below the equilibrium, supply is less than demand, and there is a risk that set health objectives will not be met. At the same time, an oversupply of labour will result in the wastage of scarce resources. Thus, it is critical to ensure that there is an equilibrium position where the supply of healthcare labour is just equal to demand. The theory, as expounded by Smits et al. (2010) considers the policies that eventually affect the demand and supply of healthcare staff to be both internal and external. Internal factors are those that originate within the health facility or health system and are to an extent under the control of the system. External factors, on the other hand, originate from outside the system but have far-reaching effects on the supply and demand for labour in the healthcare system.

The Increasing Public Healthcare Expenditure in the Health Sector

In the past years, various factors have influenced South Africa's ability to fully deliver upon its constitutional obligation to offer an excellent healthcare service to everyone (Young, 2016; Maphumulo and Bhengu, 2019). Perhaps the most notable of these factors has been the availability of adequate financial resources to fund the public healthcare system so that it can be the pillar upon which equal access to healthcare is supported and achieved (Doherty, Kirigia, Okoli, Chuma, Ezumah, Ichoku et al., 2018). Economic challenges, particularly slow economic growth, increasing public debt, decreasing business confidence, and exposure to global economic shocks have resulted in scenarios where the government is not able to fund all public expenditure demands, including healthcare capital and operational expenditure (Belcheri et al., 2017). There are, however, views from certain quarters that funding challenges in the public healthcare systems are attributable to inefficient use of resources in the public health sector, corruption, and mismanagement (Rispel, De Jager and Fonn, 2016). Regardless of the source of these problems, a notable and catastrophic symptom has been an underfunded public healthcare system that fails to meet the growing demands of South African society. Figure 1 below shows the growth in nominal and real public health expenditure for South Africa between 2014 and 2015.



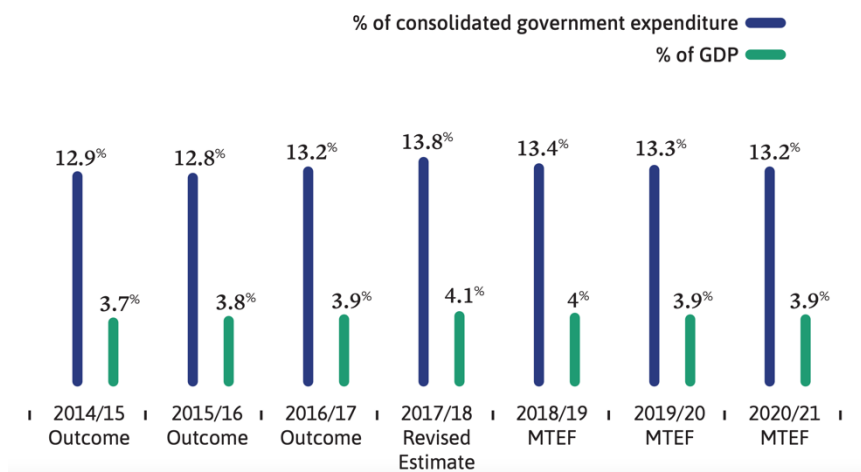
Figure 1: Nominal and real public health expenditure for South Africa 2014-2020



Source: Adapted from UNICEF (2019)

In the above graph, it can be noted that inflation-adjusted or real expenditure on public health has remained almost static between 2017 and 2020. The nominal expenditure has, however, continued to rise, increasing from R144b in 2014 to a projected R228b in 2020, representing a 58% growth. In real terms, public health expenditure grew from R144bn in 2014 to a projected R166b in 2020, a 15.3% growth. This points to a decline in government expenditure in inflation-adjusted terms, which confirms that the public sector health budget has not been growing at a pace that enables the public system to keep up with inflationary pressures. Another graph below also indicates stagnant growth in funding made to the public health sector.

Figure 2: Public health expenditure as a percentage of government expenditure and GDP



Source: Adapted from UNICEF (2020)



Figure 2 above shows that the public health budget ranged between 3.7% and 3.9% of gross domestic product (GDP) from 2014 to projected 2020. This gives the picture that government funding of the public health sector had been consistent. However, GDP at both inflation-adjusted and nominal values has been on a decline in the period under review. This points to the truth that the value of funding has also been decreasing over the period from 2014 to 2020. Thus, the public health system is confronted with a real challenge of declining funding during a period when more and more people are depending on it because of increasing unemployment (Belcheri et al.,2017).

Staffing Moratoria on the Performance of Public Healthcare Facilities

In South Africa, the public healthcare sector takes up significant portions of national budgets and as such, internal and external stakeholders are greatly concerned about how they perform (Abolhallaje Bastani, Abolhasan and Ramezanlam, 2012). Another important factor behind the increased focus on the performance of public healthcare facilities is their effect on public health. Poorly evaluated or unevaluated healthcare systems pose a risk to the public (Rahimi, Kavosi, Shojaei and Kharazmi, 2016). At the same time, public healthcare facilities with effective performance evaluation systems are in a better position to promote quality healthcare provision. This is because performance evaluation enables managers and policymakers to quickly identify challenges and address them in time before they become major disruptions to service provision (Goshtasebi, Vahdaninia, Gorgipour, Samanpour, Maftoon, Farzadi and Ahmadi, 2009). Performance evaluation in these facilities is therefore crucial in assessing current performance as well as in mapping strategies for future performance (Markic, 2014).

Sauerman (2015) points out that quality measurement has become one of the major indicators of public healthcare facility performance (Sauerman, 2015). Healthcare quality was described and classified in numerous and various ways. Baker (2001) identified six constructs that can be used as public healthcare quality measurement dimensions. These are safety, effectiveness, customer focus, time sensitivity, and equitability in sustainability. Hasa and Jones (2017) discuss the same dimensions except for sustainability. Safety refers to the degree to which facility users are protected from harm emanating from within the facility. Effectiveness refers to the extent to which services provided to patients bring about desired outcomes (Baker, 2001). Customer focus is concerned with the extent to which service and processes in the facility are patient-centric (Baker, 2001; Hasa and Jones, 2017). Time sensitivity relates to the extent that staff within the facility are conscious of the need to serve patients on time (Baker, 2001). Equitability relates to the provision of healthcare services to all health-seeking groups while sustainability relates to the system's ability to consistently provide a defined service standard given the resources limitations (Cohen and Marshall, 2017). Key performance indicators relating to the six dimensions above can help to identify the overall performance level of public healthcare facilities.



The implementation of staffing moratoria is hard-hitting for poor rural patients on the ground and has catastrophic consequences for healthcare, particularly in rural health settings (Young, 2016; PSC,2018). Provincial treasuries and health departments are encouraged to find reasonable responses to staffing moratoria within available budgets (Ferrinho, Sidat, Goma and Dussault 2012). The three most rural provinces in South Africa have the lowest doctor to patient ratios with the worst vacancy rates. Versteeg-Mojanaga, (2015) states that for rural clients, the results are numerous and can result in death. The impact on healthcare and the consequences include amongst others:

- Poor healthcare service with negative consequences– a high number of grievances
- Poor healthcare output– impacting chronic patient retention in treatment.
- Increased duration for receiving treatment– resulting in people not seeking treatment.
- Inadequate supervision and failure to follow protocols and procedures
- Increased turnaround time in responding to emergencies and
- Non-compliance with national standards of care and management of chronic illnesses

These are among other challenges that rural health hospitals are facing because of staffing moratoria (Versteeg-Mojanaga, 2015). The dilemma in today's healthcare facilities centres on how to improve quality care to patients while at the same time reducing ever-increasing staffing costs (Larson, 2017). Healthcare facilities should therefore avoid being overstaffed as this waste limited financial resources. At the same time, they should not be understaffed, as this affects service quality (Larson, 2017). Kaplan and Haas, (2014) agree with this notion and state that while cost-cutting might have immediate effects on financial reports, it has long-term negative effects on organisational performance. They note some common mistakes that healthcare facilities make in cutting staffing costs. These include:

- Cutting costs on non-clinicians without evaluating how this affects the productivity of clinicians. For example, a clinician's productivity can be reduced if they now must focus on administrative duties previously handled by a hospital clerk.
- Cutting costs without doing due diligence on the effects and impact that this has on the medical facility and its stakeholders.
- Cost-cutting without any analytical assessment of the actual budgets.
- Attempting to maximise the number of patients that clinicians can handle without consideration of healthcare quality.

For these reasons, cost-cutting through staff freezes and staff cuts often fail. The risks of such failures are often felt by patients who end up receiving poor quality service and the



employees who feel overworked and demotivated (Kaplan and Haas, 2014; Larson, 2017). The study, therefore, researches the effects of the moratorium at NTH to understand how the balance between austerity and service quality (especially as a function of staff morale and organisational performance) can be approached.

Research Methodology

The study adopted mixed designs and a non-experimental strategy to fulfil its purpose. Data was collected using both survey questionnaires and in-depth interviews. This study adopted a probability sampling strategy and used Yamanes (1967:886) simplified sampling formula to calculate sample size, which is:

$$n = \frac{N}{1 + (N)(e)^2}$$

N = Population

e = Margin of Error

n = Sample size

A stratified sampling technique was employed, and 292 survey questionnaires were distributed at Tempo Hospital among healthcare workers. The sampling process is presented below.

Figure 3: Determining sample size process for Tempo Hospital

$$n = \frac{N}{1 + (N)(e)^2}$$

$$n = \frac{1084}{1 + (1084)(0.05)^2}$$

$$n = \frac{1084}{1 + (1084)(0.0025)}$$

$$n = \frac{1084}{3,71}$$

N = 292,18

The sample size is 292 healthcare workers.

Figure 3: illustrates the formula used to determine the required sample size that would be a representation of the Tempo Hospital population and allow the researcher to generalize about the population. The research sought to have a 95% confidence level and an expected error margin of 5%. Figure 3 above shows that the required sample size was 292 from a population of 1084 healthcare workers employed at Tempo Hospital.

Out of 292 participants required for this study, only 177 healthcare workers participated in this study. On the qualitative side, interviews were used. A non-probability sampling strategy was employed. Nine respondents were key informants who participated in in-depth interviews. For confidentiality and anonymous purposes, respondents who participated in in-depth interviews were named as Respondents 1 to 9.

The collected data from healthcare workers were coded and analysed using SPSS version 25 a statistical software developed by IBM. Once the data was collected and cleaned, the research sought a basic quantitative analysis and qualitative data from in-depth interviews were analysed thematically.

Results and Discussion of the Study

This section presents the key findings of the data in accordance with the purpose of the study as stated earlier. The presentation of results starts with sample distribution by respondent's work experience, followed by the level of consultation in the implementation of staffing moratoria. The impact and challenges of staff shortages on healthcare services and service delivery at Tempo Hospital are also discussed and lastly, the impact of moratoria on staff duties at Tempo Hospital is also examined.

Sample Distribution by Work Experience

From the total number of sample data collected by work experience, 38% of the study sample had five years or less of work experience, 29% between 6 and 10 years of experience and 17% between 11 and 15 years. Therefore, it can be concluded that 62% of the sample had over 5 years of experience. From this observation, it can be implied that most of the respondents had experience in working within both staffing moratoria and non-staffing moratoria conditions over the years as the staffing moratoria was implemented in September 2015. They were therefore in a position to provide comparative views of the pre and post-moratoria periods.

Additionally, 74.2% of the managers, compared to 59.8% of non-managers had over five years of experience. These results, therefore, show that proportionally more managers



have been in service to experience the changing human resources hiring regimes in the health sector and at TH. Overall, the respondents in this study judging from work experience could give insightful views and experiences based on their long stay at TH.

Overall, the above findings show that staffing moratoria took more of a centralised approach where the Department of Health solely, made decisions on what posts to freeze in hospitals and other medical and healthcare facilities without involving healthcare workers. The weaknesses of such approaches are that they create situations where decisions are made by individuals who are not very akin to the situation on the ground and additionally, who are not quickly and easily accessible for recourse or appeal. The Department of Health needs to consider decentralised decision-making to accommodate health care workers on the ground who are faced with challenges that arise from these decisions.

The Impact of Staffing Moratoria on Staff Shortages

Out of 177 respondents who responded to questions regarding the impact of staffing moratoria on staff shortages, 91% were of the view that staffing moratoria had resulted in staff shortages. Another 8% were not sure, and 1% believed that it had not resulted in staff shortages. Staffing moratoria were therefore seen as a major cause of staff shortages at the hospital by the majority of the respondents. In the interviews, respondents expressed that while previous policy announcements on cost-cutting measures were meant to affect non-critical staff members, excluding specialized nurses and doctors, it was instead affecting all staff. Respondents further expressed that staffing moratoria affected even the critical staff, with respondents citing the shortage of doctors, nurses, and other specialised medical staff. This shortage was worsened by the fact that medical staff were resorting to doing non-medical jobs in order to compensate for shortages of administrative staff. This was worsened by the fact that even before the moratorium, there were already shortages of critical staff within the hospital.

This was asserted by a respondent who expressed that:

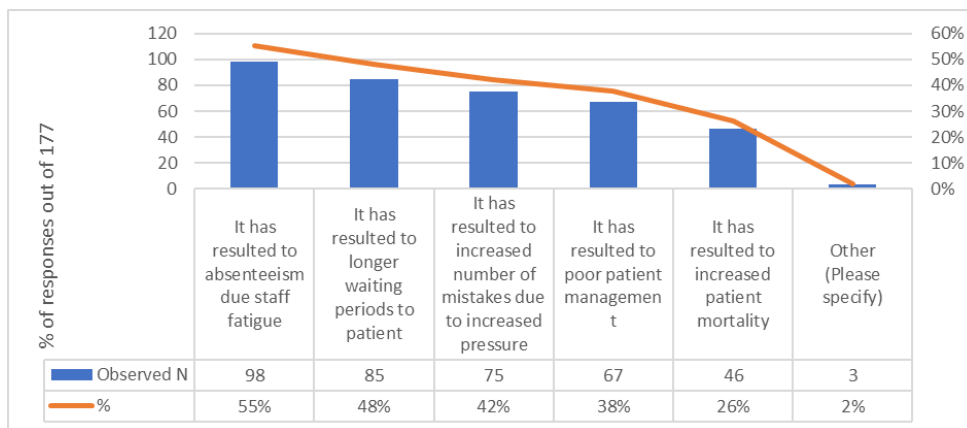
“...Staff shortages have resulted in the closure of certain services, for example, the office of the PRO because it is only one post for PRO so if you don’t have that one individual literally the office is closed. So, it leads to closure of certain critical services which are not supposed to be closed...” (Respondent 7)

The following section discussed the impact of staff shortages on healthcare services and service delivery at Tempo Hospital.

Staff Shortages on Healthcare Services and Service Delivery at Tempo Hospital

This section presents data analysis results relating to the perceived impact of staff shortages at Tempo Hospital. It also looks at the challenges that the two samples associated with the staffing moratoria. Figure 5 shows the respondents' responses to the statement: 'Impact of staff shortages on healthcare services and services in the hospital.'

Figure 4: Impact of staff shortages on healthcare services and services in the hospital



Source: Surveyed respondents (2019)

On the above statements, respondents were free to select as many responses as necessary to convey their views regarding the impact of staff shortages on healthcare services. Responses were absenteeism, waiting periods, risks of medical errors, patient management, patient mortality and others (**respondent to specify**).

Waiting Periods for Patients at TH

The interviewees also discussed the long waiting periods to which patients were being subjected. Respondents in the interviews believed that staff shortages as a result of the moratoria were responsible for patients getting service late. In the interviews, these delays were described as being both administrative and medical. On the administrative side, patients waited for long hours to get their paperwork and files processed due to fewer administrative staff than is required. On the medical side, treatment was also delayed as a result of an overwhelmed medical team that had to be content with administrative tasks as well.

In this regard, one respondent said that:



“...So, one; it is staff shortages, two; delay in curative and rehabilitation of patients’ extension of hospital length of stay and bed occupancy rates will always be full remember people are not being discharged and bed occupancy is always high or full.” (Respondent 7)

Risks of Medical Errors at TH

In the survey, 20% of the respondents believed the moratoria had increased mistakes among practitioners, due to increased work pressure. The interviewees corroborate this view, pointing out that the risks of delivering erroneous services to patients had increased in frequency, alongside the risks of litigation for negligence, also referred to as medico-legal cases. Notably, one respondent refuted that the staffing moratoria increased the number of patient incidents and litigations for negligent service, as healthcare workers overstretch themselves to provide the necessary care. The respondent stressed that:

“I cannot say that there are too many cases of patient incidence because I might say there are only a few cases even though they are short-staffed. There are those nurses we overstretch.” (Respondent 6)

Furthermore, the issue of litigation claims because of medical errors was also highlighted:

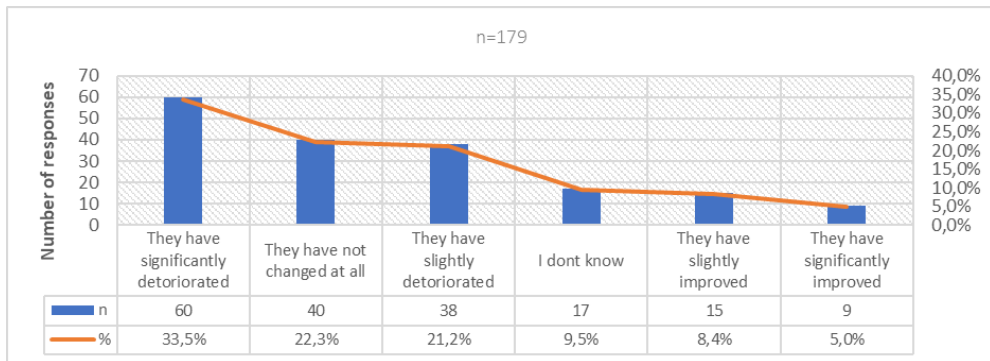
“The second one is that money supposed to be saved by the department from not employing might as well go to the increasing medico-legal cases. Meaning that the department is now being sued for millions for medico-legal cases. If there are staff shortages the service output will be of poor quality and our constitution allows people to sue the state when there are issues of malpractice.” (Respondent 7)

This view also resonates with the survey’s findings on increasing errors because of staffing moratoria. In the survey, a small number of respondents pointed out that staffing moratoria was not a cause of medication errors at the hospital although this number was not negligible. Therefore, from the results above the Department of Health will invite a situation where its quest to decrease the expenditure is unachievable because of increasing litigation claims that are caused by medical errors due to staff shortages.

Increases in Patient Mortality at TH

In the survey, 26% of the respondents associated the moratoria with an increase in patient mortality at Tempo Hospital. Two interviewees were of the view that the moratorium compromised the lives of patients. Thus, the view that moratoria were associated with a significant increase in mortality rates was held by a small, but a considerable proportion of the sample.

Figure 5: Working conditions in your department since staffing moratoria



Source: Surveyed respondents (2019)

Figure 5 above shows that after the implementation of staffing moratoria at Tempo Hospital, 33.5% believed that working conditions have significantly deteriorated, while 22.3% believed that they had not changed at all. In the interviews, respondents expressed that working conditions after the implementation of staffing moratoria had declined significantly. Before the moratorium, as expressed in the interviews, employees concentrated on their contractual duties. For instance, nurses did not have to clean the wards because of shortages of cleaning staff. They were also able to share their work with other colleagues if they felt overburdened. They also relied on nursing aids to clean and bathe patients. After the moratorium, they took care of the cleaning work as well. As a result, they were always fatigued by their work. Staff shortages compounded by absenteeism make their work difficult.

The same factors responsible for absenteeism, namely low staff morale and larger than manageable workloads, were also behind the deterioration of working conditions. As in the survey, most respondents believed that the working conditions they experienced before the moratoria were more positive compared to the current conditions.

Absenteeism and Fatigue

Out of all the 177 respondents, 98 (55%) believed that the moratoria had resulted in absenteeism due to staff fatigue. Among the respondents: 85 (48%) believed that it had resulted in longer waiting periods for patients; 75 (42%) that it had increased mistakes among practitioners due to increased work pressure; 67 (38%) that it resulted in poor patient management; and 46 (26%) that it had resulted in increased patient mortality. In the interviews, absenteeism, because of staffing moratoria was discussed at length by the respondents. There were two broad reasons behind absenteeism in staff. These were low staff morale, as well as fatigue. The respondents in the interviews further stated that it was



also morally difficult to impose heavy disciplinary penalties on employees as the employees would sometimes be exhausted because of the extra work they had to do.

This is highlighted in the below response:

“There is growing misconduct cases because of absenteeism. People are tired. Negligence people did not do what was expected of them”. **(Respondent 7)**

The respondents in the interviews were also able to outline the workers’ grievances and concerns in detail. From the interviews, the reasons behind the perceived deterioration of working conditions are shown below:

Table 1: The reasons behind the perceived deterioration of working conditions

Grievance	Example
Working with little or no rest	On a daily basis, nurses fail to take lunch breaks: in the long-term most staff were being denied annual leave.
Working longer than expected hours	Staff did not always take mandatory breaks resulting in increased working hours.
Being delegated too much work to handle	Staff had to cover for absent staff and frozen posts, this included being delegated lower tasks and also being task-shifted to higher-level tasks.
Doing work that was not on one’s job description	Nurses and other clinicians taking administrative duties and duties of general hands such as cleaning and bathing patients.
Feeling exploited by the situation	Workers who task shift felt that they were not compensated to meet the added skills levels; staff felt they were paid at the same rates as hospitals where staffing levels.

Source: Interviewed respondents (2019)

The perceived deterioration of relationships among departments was also another factor that negatively affected the working environment conditions. Except for the feeling of being exploited, all the other factors were noted as being behind low job satisfaction and the perception that the working environment was harsh by Irish healthcare workers (Ipsos-MRIB, 2014). There were therefore similarities between the grievances that the sample had and those that Irish healthcare workers had with a moratorium to freeze non-critical

posts in the Irish public healthcare system. In a study conducted in Ireland, Williams and Thomas (2017) concluded that the moratoria on medical staff hiring introduced in that country between 2008 and 2014 as part of austerity measures, despite recording some successes in curbing expenditure came with a notable deterioration in working conditions as perceived by healthcare workers. Comparing the Irish situation to that of Tempo Hospital, fewer Irish workers were dissatisfied with the working conditions emanating from the 2008-2014 moratoria, with 47% of the sample being unhappy with their working conditions compared to 54.7% in the study (33.5%+21.2%). The following section provides recommendations on how healthcare facilities such as Tempo Hospital can be able to render quality healthcare services under staffing moratoria based on the findings of this study.

Discussion

Outside the study, shortages in critical medical staff can be explained by the labour dynamics of the South African health industry. Rawat (2015) explains that even outside moratoria, South Africa generally has health staffing gaps, emanating from the low training capacity of medical professionals versus the high demand for such professionals. Rawat (2015) cites the Human Resources for Health South Africa: Strategy for the Health Sector 2012/13-2016/17 as a national strategy that was formulated before the 2016 moratoria as an attempt to decrease staff shortages in the public health sector. Thus, some of the discussed views on staff shortages emanate from beyond the moratoria, although interviewed respondents vehemently believed that the moratoria had added to these challenges. These views agree with the perceptions of the interviews that the moratorium worsened an already existing problem of critical skills shortages.

The findings of this study on the implementation of staffing moratoria in public health care systems that are already suffering from staff shortages resemble findings from the Greek (Economou, Kaitelidou, Katsikas, Siskou and Zafiropoulou, 2014), Zimbabwean (Dieleman, Watson, and Sisimayi, 2012) and Irish (MacDermott and Stone, 2013) case studies covered in the literature review above. In all these countries staff freezes were implemented even when there were policy-acknowledged deficiencies in public healthcare staffing. Zimbabwe continued with its staffing moratorium even when it had 10 public health care workers for every 10,000 persons compared to the required 23 health care workers for every 10,000 persons (UNICEF, 2018). Greece had the lowest ratio of nurses per population in the European Union (Economou et al., 2014). Like in South Africa, these labour shortage dynamics were overshadowed by the need to manage costs. Such findings appear to suggest that countries sometimes prioritized budgetary performance over public health.

Among the respondents in the interviews, the view that absenteeism is not always voluntary is captured by the interviewees. Belita et al. (2013) also discusses similar views,



classifying absenteeism into voluntary and involuntary forms. However, the respondents mostly pointed to voluntary absenteeism (following from Belita et al.) as the Hospital's core challenge. Healthcare workers simply chose not to come to work due to low morale and being overworked. Nyathi and Jooste (2008) also found workload-driven voluntary absenteeism to be a common problem in hospitals in the Limpopo Province, which resonates with the findings of this study.

In a study held on two children's hospitals in Ireland, Farelly (2011) noted that in contrast to the expectation that a staff freeze at the hospitals was going to cause increased absenteeism, absenteeism levels went down post a staffing moratorium. This is opposite to the findings of this study, where a moratorium resulted in increased absenteeism. Farelly further discusses the causes of this being the observation that with too small a staff complement, any unnecessary absenteeism from duty would have far-reaching negative effects on the health delivery system at the hospitals. Again, this also stands in contrast to the findings of this study where it emerged that there was an increase in absenteeism despite the perceptions of staff shortages.

The findings above are very comparable to conclusions from previous studies. In its report, the Versteeg-Mojanaga (2015) outlined that staffing moratoria in public health systems negatively affected the speed at which services are rendered to the public. Because of fewer than optimum staff, medical facilities were not able to provide services to patients timeously. The comparatively large volumes of patients that frequent public health facilities, when combined with low staffing levels, created the risk of delayed treatment that could worsen patients' medical situations (Versteeg-Mojanaga, 2015). Going by a view by Maphumulo and Bhengu (2019) delayed assistance to patients indicates the efficiency and effectiveness-related failures in a medical facility, the moratoria, due to its negative impact on the speed at which patients are assisted, was some cause of concern at the hospital. Maphumulo and Bhengu also suggest that without adequate staffing, it was a challenge for hospitals to implement meaningful quality improvement programmes.

In the interviews, the errors were a result of both low staff morale and dealing with increased pressure from too much work. Another section attributed the errors to inexperienced personnel taking duties beyond their training as a stopgap measure to offset staff shortages. These views agree with the conclusions by the World Health Organisation that excessive work and the staff's psychological state, as well as skill and experience, are major factors associated with medication errors in medical facilities (WHO, 2016). In another study, Mathaba, Nzimakwe, Pfano and Munapo (2013) also found that moratoria can put the lives of patients at risk due to errors and this view is similar to this study's findings.

In the literature, several scholars believe that medical errors are in critical indicator of the quality of health care services offered by an institution as highlighted in the interviewees'



views. Iravani, Fazli and Alvandi (2012), Raeisi, Yarmohammadian, Bakhsh and Gangi (2012) and Rahimi et al. (2017) identify hospital or medical facility accidents as internal process measures that show the effectiveness of staff in handling their responsibilities. Like Respondent 3, these scholars also believe that increasing accidents will erode the trust that users put in a healthcare facility. In comparison to other studies, El-Khatib and Ritcher (2009) discussed how the staffing moratoria in the health sector created a high mortality rate risk among patients. This view resonates with the findings from this study. As stated by El-Khatib and Ritcher (2009), under moratoria, public health facilities tend to focus more on reducing and meeting staffing budgets rather than on providing quality healthcare, thereby putting the lives of patients at risk. El-Khatib and Ritcher (2009) views are therefore shared by part of the sample in this study. Iravani et al. (2012), Raeisi et al. (2012) and Rahimi et al. (2017) also put mortality rates as a major indicator of healthcare facility efficiency and effectiveness in delivering services to the public. In the Zimbabwean case study, the freezing of posts in the public healthcare system was also associated with increased child mortality rates (Haley, Vermund, Moyo and Kipp, 2017). This shows the importance of maintaining an adequately sized and skilled staff complement in public hospitals in preserving lives.

Conclusion

This paper provided a clear picture of the consequences of cost-cutting strategies that are implemented without proper planning, engagement, and involvement of relevant stakeholders in the Department of Health. This compromise service quality putting communities at risk. The results have shown that staffing moratoria have had negative consequences on service delivery through adversely affecting healthcare workers' morale and engagement. The strong negative sentiments from the healthcare workers from all departments within TH suggest that the staffing moratoria have not achieved a sustainable balance between financial management and public health service quality. The results further showed that staffing moratoria at Tempo Hospital resulted in severe staff shortages and the deterioration of working conditions because of excessive working hours, job enlargement, limited personal development opportunities. Staffing moratoria also promoted distrust between employees and management that furthered job dissatisfaction at the workplace. Therefore, the paper concludes that staffing moratoria should be supported by a decentralised multi-dimensional approach in planning and implementation to ensure a collective consultative process that involves all relevant stakeholders.

Recommendations

The results have shown that there are two competing goals involved: an austerity goal driven by the Department of Treasury that brought staffing moratoria and the public healthcare goals of the Department of Health. There is a need for re-engagement between



the Provincial Treasury and Health Department to establish optimum cost-cutting strategies that will not have an adverse effect on healthcare workers' ability to provide constitutionally mandated health services to communities. A staffing level analysis on individual hospitals is required in order to achieve a balanced demand and supply of labour in health facilities. A situational analysis will also prevent a blanket approach in the implementation of freezing of posts in the provincial DOH, rather allowing individual hospitals to determine their needs in terms of staffing levels according to their priority. The paper further recommends a new and accommodative approach in the development and implementation of government strategies and policies such as staffing moratoria. The approach should be based on a collective consultative process involving, all relevant stakeholders in the provincial Department of Health, including community members, policymakers, healthcare workers (medical and non-medical) and hospital executive members.

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